



# PHYSICIAN CERTIFICATION STATEMENT (PCS) FOR NON-EMERGENCY AMBULANCE TRANSPORT

## Lynchburg Fire & EMS Department

800 Madison Street, Lynchburg, VA 24504 (434) 455-6340 - (434) 847-1742 (fax)

Please print clearly and have physician sign where indicated below. Complete ALL sections of this form.

**See reverse for important information on completing this form.**

### Section 1 – Beneficiary Information

Name:	Last Name	First Name	Middle Initial	Age:	Date of Birth:	Sex:
					____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F
SSN:	Medicare No.:		Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid No.:	
____-____-____	____-____-____		____-____-____		____-____-____	
Diagnosis:						
Date of Transport: ____/____/____				Note: The Physician Certification Statement (PCS) effective date must be no earlier than 60 days before the date services are furnished.		

### Section 2 – Transport Information

Transport From:	Discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No
Transport To:	Admit? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for Transport: (include name of service, treatment, or procedure the patient needs at the receiving facility)	
Is the service, treatment, or procedure for which patient being transported available at originating facility? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, why is transport necessary?

### Section 3 – Medical Necessity Information – See Reverse for Definition of Medical Necessity

**NOTE: LACK OF ALTERNATIVE TRANSPORTATION SERVICES DOES NOT CREATE A MEDICAL NECESSITY FOR AMBULANCE SERVICES.**


Describe patient's condition (not diagnosis) at the time of pickup and/or discharge that necessitated utilization of an ambulance. (see reverse for HCFA definition of medical necessity)

Is the patient bed confined as defined by Medicare (HCFA) regulations? (see reverse for definition) ..... ☐ Yes ☐ No  
If the patient does not meet bed-confined criteria, can this patient be safely transported by wheelchair van?..... ☐ Yes ☐ No  
If No, why?

This Patient (**check all that apply**):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Requires IV maintenance   | <input type="checkbox"/> Requires continuous oxygen                         | <input type="checkbox"/> Is ventilator dependant   |
| <input type="checkbox"/> Requires care/monitoring by trained personnel during transport    | <input type="checkbox"/> Requires cardiac or other physiological monitoring | <input type="checkbox"/> Requires airway maintenance or suctioning                           |
| <input type="checkbox"/> Required to be immobilized due to a fracture or possible fracture | <input type="checkbox"/> Requires a Balloon Pump                            | <input type="checkbox"/> Requires restraints (Other than seat belts)                         |
| <input type="checkbox"/> Is exhibiting signs of decreased level of consciousness           | <input type="checkbox"/> Is comatose & requires monitoring                  | <input type="checkbox"/> Is seizure prone & requires monitoring                              |
| <input type="checkbox"/> Has decubitus ulcers & requires wound precautions                 | <input type="checkbox"/> Requires isolation precautions (VRE, MRSA, etc.)   | <input type="checkbox"/> Weight limit exceeds wheelchair or stretcher van safety limitations |
| <input type="checkbox"/> Requires other services or equipment (please list): _____         |   |  |

### Section 4 – Ordering Physician Information and Signature

Print Name of Physician Ordering Ambulance Services:	UPIN:	Fax Number:
I certify that the above information is true and correct based on my evaluation of this patient. I understand that this information will be used by the Health Care Financing Administration to support the determination of medical necessity for ambulance service		
	Physician's Signature	Date
	Medical Support Staff Signature	Date

**Please give this form to an ambulance crew member.**

Give this PCS directly to an ambulance crew member.

## BACKGROUND

Effective February 24, 1999, HCFA requires in 42 CFR Part 410.40(d) a Physician Certification Statement (PCS) from the patient's attending physician for non-emergency ambulance transportation. This form has been designed to assist the healthcare professional to determine if Medical Necessity has been met. Please complete all sections of this form and have an appropriate healthcare provider (as noted below) sign where indicated attesting to the Medical Necessity of ambulance transportation services.

## WHO MAY SIGN THE PCS

This PCS should be signed by the patient's attending physician (or physician ordering transport). If unable to obtain the signature of the physician, this form may be signed by a member of the physician's medical support staff. Medical support staff is defined as: physician's assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner who is employed by the hospital or facility where the patient is being treated, with knowledge of the patient's condition at the time the transport was ordered or services were furnished.

## DEFINITIONS

**Medical Necessity:** Medicare covers ambulance services if they are furnished to a beneficiary whose medical condition is such that other means of transportation would be contraindicated, **irrespective if such other transportation is actually available.** In addition, for non-emergency ambulance transportation, the definition of bed confined (see below) must be met to ensure that ambulance transportation is medically necessary. The patient may be held liable for non-medically necessary services.

**Bed Confined:** All three must be met before a patient is bed confined, however bed confinement is not the sole determinant of medical necessity.

- i. The beneficiary is unable to get up from bed without assistance; and
- ii. The beneficiary is unable to ambulate; and
- iii. The beneficiary is unable to sit in a chair, or a wheelchair

### *Exception*

"[HCFA] recognize[s] that it is standard and accepted medical practice in both hospitals and nursing homes to take steps to ensure that beneficiaries are up and out of bed as often as their condition permits. Such beneficiaries are not bed-confined. It is incumbent upon health care professionals responsible for the care of individual beneficiaries to determine what is safe for those beneficiaries. If it is

determined that it is unsafe for a particular beneficiary to be unmonitored during transport, then the documentation submitted for that particular transport should support the need for ambulance transportation. That documentation will be considered by the carrier in processing the claim."

**Emergency:** Services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- i. Placing the patient's health in serious jeopardy;
- ii. Serious impairment to bodily functions; or
- iii. Serious dysfunction of any bodily organ or part.

**Non-Emergency:** Services provided to a patient whose condition does not meet the above definition for emergency are considered non-emergency. In addition, all scheduled transports, and all transports to a non-acute healthcare facility, would be considered non-emergency.

**Scheduled:** Services that have been prior arranged 24 or more hours in advance of the transport.

**Non-Scheduled:** Services that do not meet the above definition of scheduled would be considered non-scheduled.

## REQUIREMENTS FOR PCS

For non-emergency ambulance transportation services provided to Medicare beneficiaries, the Code of Federal Regulations (CFR) 410.40(d)(2) requires ambulance providers to obtain a written order from the beneficiary's attending physician, certifying that the medical necessity requirements (listed above) are met.

The physician's order must be obtained **BEFORE** the provision of services and must be dated no earlier than 60 days before transport. A separate PCS is required for each transport except in the case of multiple scheduled transports for the same diagnosis, e.g. dialysis, radiation therapy, chemotherapy, etc. In these cases, the physician certificate will be valid for 60 days from the date it is signed. For a beneficiary residing at home or in a facility who is not under the direct care of a physician, a PCS is not required.

Additional copies of this form can be downloaded from: [www.lynchburgva.gov/home/index.asp?page=366](http://www.lynchburgva.gov/home/index.asp?page=366)

Rev. 06/13/05